

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02493

## CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cecilton		LENGTH OF STAY (in this place) years.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cecilton	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main St				STREET ADDRESS (If rural give location) Main St	
3. NAME OF DECEASED (First) Robert		(Middle) Lee		(Last) Alderson	
5. SEX male		6. COLOR OR RACE white		4. DATE OF DEATH March 16 1957	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter - self employed		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Sept 16 1874	
13. FATHER'S NAME William Alderson		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday 76 yrs.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY No. 214-14-5241		11. BIRTHPLACE (State or foreign country) Cecil Co Maryland	
				12. CITIZEN OF WHAT COUNTRY? USA	
				14. MOTHER'S MAIDEN NAME Ann Eliza Register	
				17. INFORMANT Mina Alderson Boyd	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Carcinomatosis due to			
Antecedent cause(s) (b) Prostatic Carcinoma			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Aug. 1950, to March 16 1957, that I last saw the deceased alive on March 16, 1957, and that death occurred at 6:05 p.m., from the causes and on the date stated above.

SIGNATURE ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF March 18 1957		NAME OF CEMETERY OR CREMATORY Cecilton		LOCATION (City, town, or county) Cecilton		(State) Md.	
DATE REC'D BY LOCAL REG. March 19-57		REGISTRAR'S SIGNATURE Mrs. Linda W. Cheney		24. FUNERAL DIRECTOR Edward Fellows		ADDRESS Millington Md.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 20 1951  
BUREAU OF  
VETERANS

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

02494

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Pennsylvania COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) Williamsport	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location) 729 Elmira Street	
3. NAME OF DECEASED (First) JOHN (Middle) N. (Last) AULT		4. DATE OF DEATH (Month) March (Day) 16 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 23, 1892
9. AGE last birthday 58 yrs.		10. BIRTHPLACE (State or foreign country) Pennsylvania	
11. CITIZEN OF WHAT COUNTRY? USA		12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	
13. FATHER'S NAME John B. Ault - Deceased		14. MOTHER'S MAIDEN NAME Eva Nicely - Deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. None	
17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Hypertensive cardio-vascular renal disease		
Antecedent cause(s) (b) Cerebral Arteriosclerosis		
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Arteriosclerosis, generalized		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Sept. 24, 1950, to March 16, 1951, and that death occurred at 4:25 A.M., from the causes and on the date stated above.		
SIGNATURE E. P. BRANNON, M.D. Chief, Professional Services, VAH, Perry Point, Md.		DATE SIGNED 3-16-51
23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF 3-16-51	NAME OF CEMETERY OR CREMATORY Wildwood Cemetery
LOCATION (City, town, or county) (State)	LOCATION (City, town, or county) (State)	24. FUNERAL DIRECTOR
DATE REC'D BY LOCAL REG. March 14, 1951	REGISTRAR'S SIGNATURE	ADDRESS Page Funeral Home, 125 E. 3rd St., Williamsport, Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02495

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Virginia COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) South Arlington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location) 3424 - 9th Street	
3. NAME OF DECEASED (Type or Print) PAUL L. BARNES		4. DATE OF DEATH (Month) March (Day) 6 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Jan. 26, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police Captain		10b. KIND OF BUSINESS OR INDUSTRY Municipal - DC	9. AGE last birthday 57 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis Barnes - Deceased		14. MOTHER'S MAIDEN NAME Jennie Yagen - Deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. None	
17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) Pneumonia, bronchial, bilateral	3 to 4 days
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Pyelonephritis, bilateral, severe Carcinoma of the bladder with metastasis to adjacent tissues	2 weeks
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 2, 1951, to March 6, 1951, and that death occurred at 4:55 P. M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

E.P. BRANNON, M.D. Chief, Professional Services, VAH, Perry Point, Md.		3-7-51
23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF 3-7-51	NAME OF CEMETERY OR CREMATORY Columbia Gardens Arlington, Va.
DATE REC'D BY LOCAL REG. March 7, 1951	REGISTRAR'S SIGNATURE Irene S. Dayberry	24. FUNERAL DIRECTOR Martin W. Hysong Co
		ADDRESS

HYSONG'S FUNERAL HOME, 1300 N. St., N.W. Wash. DC

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

MAR 10 1951

BUREAU V. 1

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02496

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>md</b> COUNTY <b>Cecil</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>rural - North East Rd.</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Union Hospital</b>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<b>Harry</b>	<b>W</b>	<b>Burns</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>7 20 1868</b>
9. AGE last birthday <b>82</b> yrs.		10. DATE OF DEATH <b>3 13 1951</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret 12 yrs packer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tool Mfg</b>	
11. BIRTHPLACE (State or foreign country) <b>North East Rural Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Burns</b>		14. MOTHER'S MAIDEN NAME <b>Sarah ALEXANDER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY No. <b>None</b>	
17. INFORMANT <b>Mrs Rhoda B. Tyson</b>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <b>Pulmonary Edema</b>		<b>24 hrs</b>
Antecedent cause(s) (b) <b>Arteriosclerotic Heart Disease</b>		<b>10 years</b>
(c) <b>Arteriosclerotic Gangrene both big toes</b>		<b>1 month</b>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <b>6 March '51</b>	19b. MAJOR FINDINGS OF OPERATION <b>Arteriosclerotic gangrene - disl phalanx both big toes</b>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While et Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **May**, 19**46**, to **13 March 1951**, that I last saw the deceased alive on **13 March**, 19**51**, and that death occurred at **8 P. m.**, from the causes and on the date stated above.

SIGNATURE **Klaus H. Fischer M.D.** ADDRESS **North East, Md** DATE SIGNED **16 March '51**

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>3 17 1951</b>	<b>Bay View Methodist</b>	<b>North East Rural Md</b>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<b>Mar 16</b>	<b>H. L. Trager</b>	<b>Joseph R. Grant</b>	<b>North East, Maryland</b>

690 346

MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

02497

Reg. Dist. No. *92*

1. PLACE OF DEATH COUNTY <i>Beecil</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md.</i> COUNTY <i>Beecil</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake City</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Union Hospital</i>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <i>HENRIETTA</i>		4. DATE OF DEATH (Month) <i>3</i> (Day) <i>11</i> (Year) <i>1957</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <i>Married</i>	8. DATE OF BIRTH <i>7-11-1867</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>83</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Chesapeake City Md.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Richard Callahan</i>		14. MOTHER'S MAIDEN NAME <i>Liza Lucas</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY No.	
17. INFORMANT			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

*703.7* Immediate cause

Antecedent cause(s)  
 Diseases or conditions, if any,  
 giving rise to the above cause,  
 stating the underlying cause last

*186a*

(a)

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS  
 Conditions contributing in the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, or office, etc.) OF INJURY <i>Home</i>	(CITY OR TOWN) <i>Calvert</i>	(COUNTY) <i>Beecil</i>	(STATE) <i>Md.</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>3 11 51 a.m.</i>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <i>Fell on floor in wrong home</i>		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <i>Mar. 15/57</i>	NAME OF CEMETERY OR CREMATORY <i>St. Augustine</i>	LOCATION (City, town, or county) <i>Near Chesapeake City, Md.</i>	(State)
DATE REC'D BY LOCAL REG. <i>Mar 12</i>	REGISTRAR'S SIGNATURE <i>F.R. Trager</i>	24. FUNERAL DIRECTOR <i>H.W. Pippin &amp; Son</i>	ADDRESS <i>Alton, Md.</i>	

MARGIN RESERVED FOR BINDING

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RECEIVED  
MAR 14 1961  
BUREAU A. N.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02498

Reg. Dist. No. 95

1. PLACE OF DEATH COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Pd</u> COUNTY <u>York</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Seaside Sun</u> LENGTH OF STAY (in this place) <u>2 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hardline Pd</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>112 W. Pearl St</u>		STREET ADDRESS (If rural, give location) <u>Rd #1</u>	
3. NAME OF DECEASED (Type or Print) <u>Claudia K Davis</u>		4. DATE OF DEATH <u>March 5</u> 19 <u>57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 30 1859</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>	9. AGE last birthday <u>91</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>Thomas D. Dombrow</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Struthoff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Samuel J. Thompson</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>450.0 Hypostatic pneumonia</u>			
Antecedent cause(s) (b) <u>97 General Arterio sclerosis</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>HOMICIDE</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from April 5, 1950, to 3-4, 1957, that I last saw the deceased alive on 3-4, 1957, and that death occurred at 3 m., from the causes and on the date stated above.

SIGNATURE William Dockson M.D. ADDRESS Rising Sun Md DATE SIGNED 3-5-57

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>March 8 1957</u>	NAME OF CEMETERY OR CREMATORY <u>State Rd</u>	LOCATION (City, town, or county) <u>Delta Pd</u> (State)
DATE REC'D BY LOCAL REG. <u>3/5/57</u>	REGISTRAR'S SIGNATURE <u>L. M. Worthington</u>	24. FUNERAL DIRECTOR <u>W. H. Thompson</u>	ADDRESS <u>W. H. Thompson</u>

MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

02499

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Ind.</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ellettsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Warriorsburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>CATHERINE</u> (First) <u>DORSEY</u> (Last)		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Single</u>	8. DATE OF BIRTH <u>1868</u>
9. AGE last birthday <u>82</u> yrs.		10. DATE OF BIRTHDAY (If under 1 year) Months <u>8</u> Days <u>2</u> (If under 24 hrs. Hours <u>0</u> Min. <u>0</u> )	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cecil Co Ind.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Patrick Dorsey</u>		14. MOTHER'S MAIDEN NAME <u>Honore Sheehan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Union Hosp. Records</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hypostatic Pneumonia

903.7 Antecedent cause(s)  
 Diseases or conditions, if any,  
 giving rise to the above cause  
 186a stating the underlying cause last

(b) Fracture of hip & prolapse of rectum

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> PLACE (Home, farm, factory, street, etc.) <u>Residence Home</u>		(CITY OR TOWN) <u>Wilmington</u> (COUNTY) <u>New Castle</u> (STATE) <u>Del.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2</u> <u>14</u> <u>51</u> <u>1 P.</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>Fell in nursing home.</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Dr. R. L. Dodson D.M.E. Prising Sun Ind. 3-4-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/8/51</u>	NAME OF CEMETERY OR CREMATORY <u>Old Bohemia Cemetery</u>	LOCATION (City, town, or county) (State) <u>Warriorsburg Ind.</u>
DATE REC'D BY LOCAL REG. <u>Mar 5</u>	REGISTRAR'S SIGNATURE <u>H. Trazer</u>	24. FUNERAL DIRECTOR <u>G. J. Daniels</u>	ADDRESS <u>Middleburg Ind.</u>

720 826

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 7 1961

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

02500

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Penn. COUNTY Shuman	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Shuman		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Shuman	
HOSPITAL OR INSTITUTION/STREET ADDRESS Shuman Hospital		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) ELMER. Eldreth		4. DATE OF DEATH (Month) (Day) (Year) 3 12 1951	
5. SEX M.	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED Single	8. DATE OF BIRTH 8-28-21
9. AGE last birthday 29 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (State or foreign country) Shuman, Penn.		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME no information		14. MOTHER'S MAIDEN NAME Leticia Eldreth	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-18-7422	
17. INFORMANT Dr. P. Records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

822.5 Antecedent cause(s) Fracture base of skull.  
 170c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 8 Panetial bone fracture

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS  
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY 3 17 51 1951		INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? Car turned over lane					

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
Burial		March 19, 1951		Eldreth Cemetery		Shuman		Penn.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
Mar. 19		J. H. Trauer		H. H. Peppin & Son		Elkton Md.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.







# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02501

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elkton		LENGTH OF STAY (in this place) Life		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elkton			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital				STREET ADDRESS (If rural, give location) 105 South			
3. NAME OF DECEASED (Type or Print) Susie		(First)		(Middle)		(Last)	
5. SEX F		6. COLOR OR RACE Wh		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH Feb 23, 1854	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Press Making		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		9. AGE last birthday 97 yrs		4. DATE OF DEATH (Month) (Day) (Year) March 10 1957	
11. BIRTHPLACE (State or foreign country) Elkton, Md		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME J. P. Racine		14. MOTHER'S MAIDEN NAME Monther Ann Hammond	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. (If year, give war or dates of service)		17. INFORMANT AND ADDRESS Miss Nettie E. Holly		Hooverde Grove Md	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Bunchie pneumonia		March 1-57	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
11. OTHER SIGNIFICANT CONDITIONS (c) Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb 28, 1957, to March 10, 1957, that I last saw the deceased alive on March 9, 1957, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

SIGNATURE DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) Burial		DATE Mar 13/57		NAME OF CEMETERY OR CREMATORY Elkton		LOCATION (City, town, or county) (State) Elkton	
DATE REC'D BY LOCAL REG. Mar 12		REGISTRAR'S SIGNATURE J. K. Ragan		24. FUNERAL DIRECTOR H. W. Phipps & Son		ADDRESS Elkton, Md	

690448

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

02502

1. PLACE OF DEATH- COUNTY <u>Cecil</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> TOWN <u>Elkton</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>219 Howard St</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Cecil</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> TOWN <u>Elkton</u> STREET ADDRESS (If rural give location) <u>219 Howard St.</u>	
3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>H</u> (Middle) <u>Hastneth</u> (Last)		4. DATE OF DEATH <u>March 24</u> 19 <u>57</u> (Month) (Day) (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 8, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Court Stenographer</u>	9. AGE last birthday <u>72</u> yrs. <u>1</u> months <u>13</u> days <u></u> hours <u></u> min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Michael Hastneth</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Cotter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT <u>John J. Hastneth Jr.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Pulmonary Edema</u>	<u>1 day</u>
442X Antecedent cause(s)	(b) <u>Cerebral hemorrhage</u>	<u>Feb 28, 51</u>
131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Cardio renal vascular</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 1951, to Mar 24, 1957, that I last saw the deceased alive on Mar 24, 1957, and that death occurred at 7:45 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>March 27, 1957</u>	<u>Lanham Cemetery</u>	<u>Elkton</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Mar 26</u>	<u>H K Frazier</u>	<u>H K Pippin</u>	<u>Elkton, Md.</u>	

350808

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 27 1951  
W. NEAL  
V. B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02503  
Reg. Dist. No. 92

1. PLACE OF DEATH- COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>		STREET ADDRESS (If rural, give location) <u>234 W. Main St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Charles</u>	(Middle) <u>Henry</u>	(Last) <u>HoY</u>
4. DATE OF DEATH	(Month) <u>Mar</u>	(Day) <u>1</u>	(Year) <u>1951</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Wh.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 5 1870</u>
9. AGE last birthday <u>80</u> yrs.	If under 1 year Months <u></u> Days <u></u>	If under 24 hrs. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chairman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana Pa</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>George W. HoY</u>		14. MOTHER'S MAIDEN NAME <u>Lorah Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT AND ADDRESS <u>Wm. H. Bonds Elkton, Md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Intestinal obstruction</u>		<u>1 week</u>
Antecedent cause(s) (b) <u>Carcinoma of the stomach with metastases</u>		<u>3 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>June 1, 1948</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of pyloric an of stomach</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u></u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u></u>	(CITY OR TOWN) <u></u> (COUNTY) <u></u> (STATE) <u></u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u>	INJURY OCCURRED While at <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u></u>
22. I hereby certify that I attended the deceased from <u>May 1</u> , 19 <u>48</u> , to <u>March 1</u> , 19 <u>51</u> ; that I last saw the deceased alive on <u>March 1</u> , 19 <u>51</u> , and that death occurred at <u>9 A</u> m., from the causes and on the date stated above.		
SIGNATURE <u>R. Hugh Arnes Jr</u> (Degree or title) <u>M.D.</u>		ADDRESS <u>Elkton, Maryland</u> DATE SIGNED <u>3/2/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Mar. 4/51</u>	NAME OF CEMETERY OR CREMATORY <u>Elkton</u> LOCATION (City, town, or county) <u>Md</u> (State) <u></u>
DATE REC'D BY LOCAL REG. <u>Mar 3</u>	REGISTRAR'S SIGNATURE <u>H. Trazer</u>	24. FUNERAL DIRECTOR <u>H. W. Kipp &amp; Son</u> ADDRESS <u>Elkton, Md</u>

763-699

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

02504

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY Cecil		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) Rising Sun		CITY (If outside corporate limits, write RURAL and give nearest town) Rising Sun	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) ANN		4. DATE OF DEATH (Month) 0 (Day) 22 (Year) 1961	
5. SEX F.		6. COLOR OR RACE White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED		8. DATE OF BIRTH 10-3-1863	
9. AGE last birthday 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homewife	
11. BIRTHPLACE (State or foreign country) Cecil Co Md		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Milton Nesbitt		14. MOTHER'S MAIDEN NAME Rebecca Murphy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Walter Buels			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause Coronary Thrombosis		
(b) Antecedent cause(s) Arterio sclerosis		
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE (Degree or title) Dr. R. LeDucson DATE SIGNED 3-23-61

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF 3/25/1961	NAME OF CEMETERY OR CREMATORY West Nottingham	LOCATION (City, town, or county) Coloma Cecil	(State) Md.
DATE REC'D BY LOCAL REGISTRY 24-1961	REGISTERAR'S SIGNATURE L. M. Northington	14. FUNERAL DIRECTOR Ralph M. Reed Rising Sun Md.		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 28 1951  
LIBRARY A 2



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location) 823 Pierce Street	
3. NAME OF DECEASED (First) JAMES (Middle) D. (Last) JONES		4. DATE OF DEATH (Month) March (Day) 19 (Year) 1951	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Separated	8. DATE OF BIRTH July 21, 1895
9. AGE last birthday 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Saunders Moss		14. MOTHER'S MAIDEN NAME Mariah Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. None	
17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
Immediate cause (a) Pneumonia, bronchial, bilateral	
Antecedent cause(s) (b) Urethral obstruction	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Cystitis, acute & chronic	
II. OTHER SIGNIFICANT CONDITIONS	
Conditions contributing to the death but not related to the disease or condition causing death. Renal obstruction bilateral due to the Cystitis & Urethritis	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan. 10, 1951, to March 19, 1951, and that death occurred at 8:57 a.m., from the causes and on the date stated above.

SIGNATURE E. P. BRANNON, M.D. Chief, Professional Services, VAH, Perry Point, Md. DATE SIGNED 3-21-51

23. BURIAL, CREMATION REMOVAL (Specify) Removal DATE THEREOF 3-21-51 NAME OF CEMETERY OR CREMATORY Baltimore National LOCATION (City, town, or county) Baltimore, Md. (State)

DATE REC'D BY LOCAL REG. 3-21-51 REGISTRAR'S SIGNATURE Charles R. Law 802 Madison Ave. ADDRESS 802 Madison Ave, Baltimore, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



# MARYLAND STATE DEPARTMENT OF HEALTH

Evidence for addition  
of #21 shown on:

2411 N. Charles Street, Baltimore

02506

FILM No. G 151 MAR 20 1951

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH- COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Near Elkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Near Elkton, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Elkton RD. 4/ Md.</u>		STREET ADDRESS (If rural, give location) <u>Elkton, RD. 4/ Md.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Mary</u> <u>Kramarczyk</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>March</u> <u>6</u> <u>1951</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>Wh.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar 11, 1879</u>
9. AGE last birthday <u>71</u> yrs.		10. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>	
13. FATHER'S NAME <u>No Inf.</u>		14. MOTHER'S MAIDEN NAME <u>No Inf.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>John Kramarczyk</u> <u>Elkton RD4, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	<u>Congestive thrombosis</u>		<u>30 minutes</u>
Antecedent cause(s) (b)	<u>Brachycephalic, bilateral</u>		<u>2 weeks</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	<u>Apertures rib, st.</u>		<u>10 days</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

21. ACCIDENT (Specify) SUICIDE HOMICIDE <u>accident</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>home</u>	(CITY OR TOWN) <u>Elkton, Cecil, Md.</u>	(COUNTY) <u>Cecil, Md.</u>	(STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2/25/51</u> <u>morning</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>fell out of bed &amp; fell to floor again</u> (8/20/51 etc)		

22. I hereby certify that I attended the deceased from March 4, 1951, to March 6, 1951, that I last saw the deceased alive on March 6, 1951, and that death occurred at 6:20 m., from the causes and on the date stated above.

SIGNATURE Dr. Joseph J. Kramarczyk M.D. ADDRESS Elkton, Md. DATE SIGNED 3/8/51

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Mar. 16/51</u>	NAME OF CEMETERY OR CREMATORY <u>New Catholic Cent.</u>	LOCATION (City, town, or county) <u>Elkton, Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>Mar 9</u>	REGISTRAR'S SIGNATURE <u>H. B. Traeger</u>	24. FUNERAL DIRECTOR <u>W. H. Kramarczyk &amp; Son</u> <u>Elkton, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
MAR 14 1951  
B. A. RYAN

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

02507

Reg. Dist. No. 92

1. PLACE OF DEATH- COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton RD 4</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton RD 4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JOSEPH M LODGE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3 12 1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>MARRIED</u>	8. DATE OF BIRTH <u>8-30-1882</u> 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		11. BIRTHPLACE (State or foreign country) <u>Elkton Md.</u>	
13. FATHER'S NAME <u>Richard Lodge</u>		14. MOTHER'S MAIDEN NAME <u>Jane Maule</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>214-149396</u>	
17. INFORMANT <u>Cynthia C Lodge</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
241x Immediate cause (a) <u>Acute Coronary Thrombosis</u>		
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Chronic Asthma</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE (Degree or title) <u>R. E. Dodson M.D.</u>		ADDRESS <u>Dr E. Dodson Md</u>		DATE SIGNED <u>3-12-51</u>
23. BURIAL, CREMATION (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Mar. 15/51</u>	<u>Gelpin Manor Memorial Pk</u>	<u>Elkton, Md</u>	
DATE REC'D BY LOCAL REG. <u>Mar 14</u>	REGISTRAR'S SIGNATURE <u>J. H. Frazer</u>	24. FUNERAL DIRECTOR <u>H. W. Pippin &amp; Son</u>	ADDRESS <u>Elkton, Md</u>	

510 546

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED

MAR 15 1951

ST. PAUL V. S.

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

02508

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Del.</u> COUNTY <u>New Castle</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Wilmington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>		STREET ADDRESS (If rural, give location) <u>304th Rodney St.</u>	
3. NAME OF DECEASED (Type or Print) <u>JOSEPH LORIN MASTIN</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>20</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>1-19-1914</u>
9. AGE last birthday <u>37</u> yrs.		10. If under 1 year: Months <u>0</u> Days <u>20</u> Hours <u>00</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Circle Machine Repairs</u>		10b. KIND OF BUSINESS OR OCCUPATION <u>Wilmington, Del.</u>	
11. BIRTHPLACE (State or foreign country) <u>Del.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph L. Mastin</u>		14. MOTHER'S MAIDEN NAME <u>Ellie Dillon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>141-03-6362</u>	
17. INFORMANT <u>Margaret Hawthorne</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>Fracture Parietal bones. Fract. Rt. clavicle</u>		
Antecedent cause(s) <u>866.1 Rt arm, Rt femur. Partial amputation of Rt foot. Fract. left femur left ankle.</u>		
173 <u>Crushed chest. Broken neck.</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, or other place, etc.) <u>Elkton RD Cecil Ind</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3 20-01 1951</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Crash in plane.</u>

22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Dr R L Dodson D.M.E.</u>		ADDRESS <u>Wilmington Ind.</u>	
DATE SIGNED <u>3-20-51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>March 20, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Riverside Cemetery</u>	LOCATION (City, town, or county) (State) <u>Wilmington Del.</u>
DATE REC'D BY LOCAL REG <u>Mar 21</u>	REGISTRAR'S SIGNATURE <u>H. H. Frazier</u>	24. FUNERAL DIRECTOR <u>H. W. Pippin &amp; Son</u>	ADDRESS <u>Elkton Md.</u>

550-816

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
MAY 22 1951  
BUREAU OF THE  
NAVY



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02509

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY <u>Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> TOWN <u>2 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>North East</u> TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital - Elkton Md</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mildred</u> (Middle) <u>Garey</u> (Last) <u>McCauley</u>	4. DATE OF DEATH	(Month) <u>March</u> (Day) <u>2</u> (Year) <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>3-30-1895</u>
9. AGE last birthday <u>55</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>North East, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George O. Garey</u>		14. MOTHER'S MAIDEN NAME <u>Addie Alexander</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Charles O. McCauley</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause	(a) <u>Uremic Convulsions</u>	INTERVAL BETWEEN ONSET AND DEATH <u>11 weeks about 5 years</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Chronic Interstitial Nephritis</u>	
	(c) <u>Uremic Convulsions - Uremic Coma</u>	

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
HOMICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 19, 1951, to Mar 2, 1951, that I last saw the deceased alive on March 1, 1951, and that death occurred at 9:05 A m., from the causes and on the date stated above.

SIGNATURE <u>H. Arthur Pennington M.D.</u>	(Degree or title)	ADDRESS <u>North East, Maryland</u>	DATE SIGNED <u>Mar 2 1951</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>CREMATION</u>	<u>3-4-1951</u>	<u>SILVERBROOK</u>	<u>WILMINGTON, NEW CASTLE, DEL</u>
DATE REC'D BY LOCAL REG. <u>Mar 3</u>	REGISTRAR'S SIGNATURE <u>H. B. Frazer</u>	24. FUNERAL DIRECTOR	ADDRESS <u>Joseph P. Frank North East, Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 5 1956  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 91

02510

1. PLACE OF DEATH COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u>	(Middle) <u>R.</u>	(Last) <u>Moore</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Wh.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 15, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ad. Job</u>	9. AGE last birthday <u>74</u> yrs. <u>3</u> Months <u>7</u> Days <u>11</u> Hours <u>1957</u>
11. BIRTHPLACE (State or foreign country) <u>Bohemia, Marion, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John R. Moore</u>		14. MOTHER'S MAIDEN NAME <u>Sarah</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Albert Moore</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) General embolism

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) chronic myocarditis

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 3-10-1957, to 3-11-1957, that I last saw the deceased

alive on 3-10-1957, and that death occurred at 12:25 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Buried</u>	<u>Mar. 24, 1957</u>	<u>Bethel</u>	<u>Chesapeake City</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>March 14-1957</u>	<u>Wm. J. P. P. P.</u>	<u>H. W. Pippin &amp; Son</u>	<u>Elkton, Md.</u>	

970 VVV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 15 1951

REAU V. B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

02511

1. PLACE OF DEATH COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>		STREET ADDRESS (If rural give location) <u>R.D. #3</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mary</u>	(Middle) <u>A.</u>	(Last) <u>Mullen</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept 2, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maids</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Elkton Md.</u>
13. FATHER'S NAME <u>Dennis Mullen</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Leuth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Robert Mullen</u>			

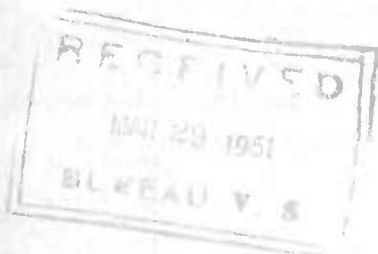
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Acute Cardiac dilatation</u>		<u>1 hour</u>
Antecedent cause(s) (b) <u>Chronic Endocarditis</u>		<u>5 yrs +</u>
(c) <u>Chronic Interstitial Nephritis</u>		<u>5 years +</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>July 1</u> , 19 <u>49</u> , to <u>March 25</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>March 25</u> , 19 <u>51</u> , and that death occurred at <u>4 P.m.</u> , from the causes and on the date stated above.		
SIGNATURE <u>Hebert Bates</u> (Degree or title) <u>M.D.</u>		DATE SIGNED <u>March 26-1951</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>March 29, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Conception</u>
LOCATION (City, town, or county) (State)	<u>Near Elkton Md</u>	
DATE REC'D BY LOCAL REG. <u>Mar 27</u>	REGISTRAR'S SIGNATURE <u>F.H. Frazer</u>	24. FUNERAL DIRECTOR <u>H.W. Pippin &amp; Son</u> ADDRESS <u>Elkton Md</u>

720836

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

3160

1. PLACE OF DEATH COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>		STREET ADDRESS (If rural, give location) <u>R.D.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Peter</u> (Middle) <u>H.</u> (Last) <u>Murphy</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>27</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 8, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vice President</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Production</u>	9. AGE last birthday <u>61</u> yrs.
13. FATHER'S NAME <u>Maurice Murphy</u>		14. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>11-45</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Herman Stuart</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. MOTHER'S MAIDEN NAME <u>Eliza McCray</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>420.1 Acute myocardial infarct.</u>		(a)	<u>4 hours</u>
Antecedent cause(s) <u>131a Cardio-vascular-reneal disease.</u>		(b)	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>131a</u>		(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from March 27, 1951, to March 27, 1951, that I last saw the deceased alive on 3/27, 1951 and that death occurred at 11:45 m., from the causes and on the date stated above.

SIGNATURE <u>Dr. J. H. Spuecher, M.D.</u>		ADDRESS <u>Elkton, Md.</u>		DATE SIGNED <u>March 27, 1951</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>St Paul</u>		LOCATION (City, town, or county) (State) <u>Arlington, Mass.</u>	
DATE REC'D BY LOCAL REG. <u>Mar 28</u>		REGISTRAR'S SIGNATURE <u>F. J. Rager</u>		24. FUNERAL DIRECTOR <u>H. W. Pippin &amp; Son</u>	
				ADDRESS <u>Elkton Md.</u>	

290-387

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
APR 2 1951  
BUREAU T. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

02512

1. PLACE OF DEATH- COUNTY <b>Cecil County</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Kent</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Perry Point, Md.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Betterton</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Veterans Administration Hospital</b>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <b>JOSEPH</b> (Middle) <b>C</b> (Last) <b>PARENT</b>	4. DATE OF DEATH (Month) <b>March</b> (Day) <b>6</b> (Year) <b>1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>August 29, 1918</b>
9. AGE last birthday <b>32</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Art. Assembler Helper</b>	
11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Parent - Deceased</b>		14. MOTHER'S MAIDEN NAME <b>Grace Fortin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY No. <b>191-01-6475</b>	
17. INFORMANT AND ADDRESS <b>Hospital Records, VAH, Perry Point, Md.</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <b>Uremia, Uremic Poisoning</b>		<b>1 week</b>
Antecedent cause(s) (b) <b>Edema, pulmonary, bilateral</b>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>Anasarca - Polyarteritis</b>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Feb. 2, 1951**, to **March 6, 1951**, and that death occurred at **8:40 p.m.**, from the causes and on the date stated above.

SIGNATURE **E. P. Brannon** (Degree or title) **Chief, Professional Services, VAH, Perry Point, Md.** ADDRESS **3-7-51** DATE SIGNED **3-7-51**

23. BURIAL, CREMATION REMOVAL (Specify) **Removal** DATE THEREOF **3-7-51** NAME OF CEMETERY OR CREMATORY **National Cemetery** LOCATION (City, town, or county) **Baltimore, Md.** (State)

DATE REC'D BY LOCAL REG. **March 7, 1951** REGISTRAR'S SIGNATURE **Dr. E. D. Dougherty** 24. FUNERAL DIRECTOR **Pennington & Son** ADDRESS **Havre de Grace, Md.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02513

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural R.D. #5</u> LENGTH OF STAY (in this place) <u>10 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>R.D. #5</u> <u>Elkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Elkton</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) <u>Harry</u> (Middle) <u>Wesley</u> (Last) <u>Pinder</u>	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>3</u> (Year) <u>1951</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 12, 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm hand</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Farming</u>	9. AGE last birthday <u>66</u> yrs. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
13. FATHER'S NAME <u>Henry Pinder</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Pinder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Bessie Pinder</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cardio-vascular - Renal - Disease</u>	Two years.	
442X Antecedent cause(s) (b) <u>13/a</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u></u>	19b. MAJOR FINDINGS OF OPERATION <u></u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u></u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u></u>	(CITY OR TOWN) <u></u> (COUNTY) <u></u> (STATE) <u></u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u></u>

22. I hereby certify that I attended the deceased from October, 1949, to March 3, 1951, that I last saw the deceased alive on March 2, 1951, and that death occurred at 11:45 p.m., from the causes and on the date stated above.

SIGNATURE <u>Noted H. Spradler, M.D.</u>	ADDRESS <u>Elkton, Maryland</u>	DATE SIGNED <u>March 4, 1951</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Mar. 6/51</u>	NAME OF CEMETERY OR CREMATORY <u>Millington</u>
LOCATION (City, town, or county) <u>Millington, Md.</u>	(State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>Mar 5</u>	REGISTRAR'S SIGNATURE <u>H. H. Trazar</u>	24. FUNERAL DIRECTOR <u>H.W. Lippin</u>
		ADDRESS <u>Elkton Md.</u>



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

02514

Reg. Dist. No. *92*

1. PLACE OF DEATH COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md.</i> COUNTY <i>Cecil</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Back of Moffitt</i>		STREET ADDRESS (If rural, give location) <i>Back of Moffitt St.</i>	
3. NAME OF DECEASED (Type or Print) <i>HENRIETTA</i> (First) <i>M</i> (Middle) <i>PINER</i> (Last)		4. DATE OF DEATH (Month) <i>3</i> (Day) <i>28</i> (Year) <i>1951</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>single</i>	8. DATE OF BIRTH <i>July 6, 1894</i> 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>		11. BIRTHPLACE (State or foreign country) <i>Elkton Md.</i>	
13. FATHER'S NAME <i>Benjamin Piner</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Anderson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		17. INFORMANT <i>Hattie Laws</i>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

*420.1*

Antecedent cause(s)

*94a* Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(a) *Acute coronary thrombosis*

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS  
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

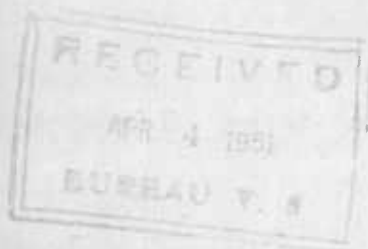
REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02515

Reg. Dist. No. 92

1. PLACE OF DEATH- COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ELKTON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ELKTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>241 W. Main St.</u>		STREET ADDRESS (If rural give location) <u>241 W Main St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Ella</u> (Middle) <u>C</u> (Last) <u>Powell</u>	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>31</u> (Year) <u>1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>February 5, 1878</u> 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>	9. AGE last birthday <u>73</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTH PLACE (State or foreign country) <u>Cecil Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Robert M. Cameron</u>		14. MOTHER'S MAIDEN NAME <u>Unnie Pleasant</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <u>Burton Powell</u>	

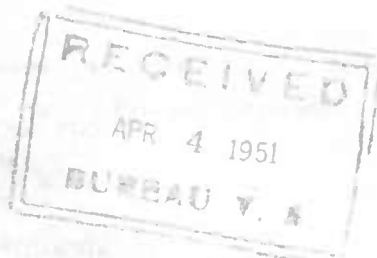
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>
Immediate cause (a) <u>Cerebral Accident -</u>			
Antecedent cause(s) (b) <u>1. Hemorrhage</u> <u>Cardio. vascular. Renal disease</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>None</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 30, 1951, to March 31, 1951, that I last saw the deceased alive on March 30, 1951, and that death occurred at 5:45 a.m., from the causes and on the date stated above.

SIGNATURE <u>Paulford K. Brecher, M.D. Elkton, Md.</u>	(Degree or title)	ADDRESS <u>North East Md.</u>	DATE SIGNED <u>March 31, 1951</u>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Mar. 3/51</u>	<u>North East</u>	<u>Md.</u>
DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>April 3</u>	<u>JR Snager</u>	<u>H.W. Pappas &amp; Son</u>	<u>Elkton, Md.</u>





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

02516

1. PLACE OF DEATH COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Cecil</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>	
TOWN <i>Elkton</i>		TOWN <i>Elkton</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>121 Collins St</i>		STREET ADDRESS (If rural give location) <i>121 Collins St</i>	
3. NAME OF DECEASED (First) <i>Florence</i> (Middle) <i>Priscilla</i> (Last) <i>Priscilla</i>		4. DATE OF DEATH (Month) <i>3</i> (Day) <i>8</i> (Year) <i>1957</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>May 25, 1870</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Maids</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	9. AGE last birthday <i>80</i> yrs. <i>10</i> Months <i>10</i> Days <i>10</i> Hours <i>10</i> Min.
13. FATHER'S NAME <i>Charles Holmes</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		14. MOTHER'S MARDEN NAME <i>Rose Holmes</i>	
16. SOCIAL SECURITY No. <i>(blank)</i>		17. INFORMANT <i>Rose P. Drunlap</i>	

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 Immediate cause (a) *Myocardial infarction - Hemile*

93d Antecedent cause(s) (b) *Arteriosclerosis*

(c) *Arteriosclerosis*

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) <i>(blank)</i>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>(blank)</i>	(CITY OR TOWN) <i>(blank)</i>	(COUNTY) <i>(blank)</i>	(STATE) <i>(blank)</i>
SUICIDE	INJURY	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>		
HOMICIDE				
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>(blank)</i>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <i>(blank)</i>		

22. I hereby certify that I attended the deceased from *Jan 1, 1957*, to *3-8-57*, that I last saw the deceasedalive on *3-7-57*, and that death occurred at *4:40* m., from the causes and on the date stated above.SIGNATURE (Degree or title) *James J. Hunsdale, M.D.* ADDRESS *Elkton* DATE SIGNED *3-9-57*

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>Mar 10, 1957</i>	NAME OF CEMETERY OR CREMATORY <i>Colored Cemetery</i>	LOCATION (City, town, or county) <i>Elkton</i>	(State) <i>MD</i>
DATE REC'D BY LOCAL REG. <i>Mar 10</i>	REGISTRAR'S SIGNATURE <i>J. K. Trager</i>	24. FUNERAL DIRECTOR <i>H. H. Pappert Son</i>	ADDRESS <i>Elkton, Md.</i>	

720836

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 14 1961  
F. O. B. A. B.

## MARYLAND STATE DEPARTMENT OF HEALTH

02517

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 92

1. PLACE OF DEATH - COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Md. COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) Elkton		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Elkton Rd 4'	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital				STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) John (First) EDWARD (Middle) REEVES (Last)		4. DATE OF DEATH 3 5 51		5. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.	
6. SEX M	7. COLOR OR RACE White	8. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	9. DATE OF BIRTH 3-5-51	10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.	
11a. USUAL OCCUPATION (Specify kind of work done during most of last year (even if retired)) Proprietor		11b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elkton Md.	
12. FATHER'S NAME Gator Reeves		13. MOTHER'S MAIDEN NAME Ruby Brunmit		14. CITIZEN OF WHAT COUNTRY U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY No.		17. INFORMANT Helen Price	

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

Premature Imposition

## Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

## PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

## (CITY OR TOWN)

## (COUNTY)

## (STATE)

## TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

## HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.

## SIGNATURE

(Degree or title)

## ADDRESS

## DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

## (State)

## DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

503051 14/13/IV

RECEIVED  
MAR 7 1951  
H. READ

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

02518

Reg. Dist. No. *92*

1. PLACE OF DEATH COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Ind.</i> COUNTY <i>Cecil</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Chester Rural, Md.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Chester Rural</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Pleasant Hill</i>		STREET ADDRESS (If rural, give location) <i>Pleasant Hill</i>	
3. NAME OF DECEASED (Type or Print) <i>RICHARD IRWIN ROBERTS</i>		4. DATE OF DEATH (Month) <i>3</i> (Day) <i>29</i> (Year) <i>1961</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <i>Married</i>	8. DATE OF BIRTH <i>7-17-1898</i>
9. AGE last birthday <i>62</i> yrs.		10. If under 1 year Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chester</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Employed</i>	
11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jesse S Roberts</i>		14. MOTHER'S MAIDEN NAME <i>Theresa B. Roberts</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>217-18-6221</i>	
17. INFORMANT <i>Frances J. Roberts</i>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) *Acute Coronary Thrombosis*

(c)

11. OTHER SIGNIFICANT CONDITIONS  
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH - COUNTY <u>Cecil</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lewisville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lewisville B.D.-5 Elkton</u>	
TOWN <u>R.D.-5 Elkton</u>		TOWN <u>Lewisville B.D.-5 Elkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) <u>Ida</u> (Middle) <u>M.</u> (Last) <u>Robinson</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>25</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 7, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE last birthday <u>68</u> yrs. <u>9</u> Months <u>7</u> Days <u>9</u> Hours <u>19</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Philadelphia Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John B. Wheeler</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elliott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Carl A. Robinson</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Myocardial Infarct</u>		420.1 Antecedent cause(s) <u>Coronary Sclerosis - generalized arteriosclerosis -</u>	Inst.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>None</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>None</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>None</u>	(CITY OR TOWN) <u>None</u>	(COUNTY) <u>None</u> (STATE) <u>None</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>None</u>	

22. I hereby certify that I attended the deceased from Feb. 14, 1951, to March 25, 1951, that I last saw the deceased alive on March 23, 1951, and that death occurred at 7:30 a.m., from the causes and on the date stated above.

SIGNATURE <u>Dr. H. H. Wheeler, M.D.</u>		ADDRESS <u>Elkton, Md.</u>		DATE SIGNED <u>March 25, 1951</u>	
23. CREMATION REMOVAL (Specify) <u>Removal</u>	DATE <u>March 28, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Mount Moriah</u>	LOCATION (City, town, or county) <u>Philadelphia Pa</u>	(State) <u>Pa</u>	
DATE REC'D BY LOCAL REG. <u>Mar 25</u>	REGISTRAR'S SIGNATURE <u>J. H. Traeger</u>	24. FUNERAL DIRECTOR <u>W. W. Pippin &amp; Son</u>		ADDRESS <u>Elkton Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

02520

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY		Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE		Maryland		COUNTY			
CITY (If outside corporate limits, write RURAL and OR give nearest town)		Perry Point		LENGTH OF STAY (in this place)		2 mo. 13 days		CITY (If outside corporate limits, write RURAL and give nearest town)		Baltimore County 20,	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Veterans Administration Hospital		STREET ADDRESS		Box 796, Route #14					
3. NAME OF DECEASED (Type or Print)		ROBERT		(First)		H.		(Middle)		(Last)	
5. SEX		Male		6. COLOR OR RACE		White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		Married	
8. DATE OF DEATH		March		22		1951		9. AGE last birthday		54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Caretaker		10b. KIND OF BUSINESS OR INDUSTRY		Private Estates		11. BIRTHPLACE (State or foreign country)		Pennsylvania	
13. FATHER'S NAME		Howard F. Runkle - Deceased		14. MOTHER'S MAIDEN NAME		Emma Baker		12. CITIZEN OF WHAT COUNTRY?		USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		Yes		16. SOCIAL SECURITY NO.		Unknown		17. INFORMANT AND ADDRESS		Hospital Records, VAH, Perry Point, Md.	

18. MEDICAL CERTIFICATION								INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH									
Immediate cause (a) Hemorrhage, subarachnoid, massive									
Antecedent cause(s) (b) Melanosarcoma, metastatic, generalized									
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)									
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
-----								Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		-----		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from Jan. 9, 1951, to March 22, 1951, and that death occurred at 12:10 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

E.P. BRANNON, M.D. Chief, Professional Services, VAH, Perry Point, Md. 3-22-51

23. BURIAL, CREMATION  
REMOVAL (Specify)
 DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) || Removal | 3/22/51 | Baltimore National | Baltimore, Md. |  |
| DATE REC'D BY LOCAL REG. | 3/22/51 | REGISTRAR'S SIGNATURE | GENERAL DIRECTOR | ADDRESS |
|  |  | Dr. E. Dougherty | Sardah T. ... | LASSAHN FUNERAL HOME, Bel Air Ave. Balto. Md. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

02521

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location) 4100 Granite Avenue	
3. NAME OF DECEASED (First) WILLIAM (Middle) H. (Last) SANDKUHLER		4. DATE OF DEATH (Month) March (Day) 18 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Feb. 22, 1896
9. AGE last birthday 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Sandkuhler - Deceased		14. MOTHER'S MAIDEN NAME Anna Brachschmidt - Deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY No. Unknown	
17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.			

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hemorrhage, cerebral, intraventricular, right

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerosis, generalized, severe

(c)

### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE HOMICIDE

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☒ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 16, 1930, to March 18, 1951, and that death occurred at 10:20 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

E. P. BRANNON, M.D. Chief, Professional Services, VAH, Perry Point, Md.

3-19-51

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF 3-19-51

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

March 19, 1951 Irene E. Dougherty Leonard Ruck, 5305 Hardford Rd., Balto. Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

02522

1. PLACE OF DEATH COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Port Deposit, Rural, Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Port Deposit, Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Cecil</u>	(Middle) <u>Clyde</u>	(Last) <u>Squier</u>
4. DATE OF DEATH	(Month) <u>3</u>	(Day) <u>- 20</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>6-25-1870</u>
9. AGE last birthday <u>80</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rev. John Squier</u>		14. MOTHER'S MAIDEN NAME <u>Isabella Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. (If year, give war or dates of service)	
17. INFORMANT AND ADDRESS <u>Miss Caroline W. Stump, Perryville, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Cerebral Haemorrhage</u>		<u>1 da.</u>	
Antecedent cause(s) (b) <u>Chronic Vascular Heart Disease</u>		<u>5 yrs</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from 3/1, 1951, to 3/20, 1951, that I last saw the deceased alive on 3/20, 1951, and that death occurred at 1:30 a.m., from the causes and on the date stated above.

SIGNATURE J. F. Magraw M.D. ADDRESS Perryville Md DATE SIGNED 3/21/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3-23-1951</u>	<u>West Nottingham</u>	<u>Colora, Md. Rural</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Mar 23, 1951</u>	<u>Irma E. Dougherty</u>	<u>W. A. Patterson &amp; Son</u>	<u>Perryville, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

470746

RECEIVED  
MAR 29 1951  
EX-104



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

02523

Reg. Dist. No. 96

1. PLACE OF DEATH - COUNTY <u>Sevier</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Ind.</u> COUNTY <u>Sevier</u>	
CITY (If outside corporate limits, write nearest town) <u>Principals Furnace</u>		CITY (If outside corporate limits, write nearest town) <u>Principals Furnace</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Shedrick</u> (First) <u>STEPHENS</u> (Last)		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Single</u>	8. DATE OF BIRTH <u>5-20-1903</u>
9. AGE last birthday <u>47</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life) <u>Principals Furnace</u>	
11. BIRTHPLACE (State or foreign country) <u>Yanceyville NC</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Thomas Stephens</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Hall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>2 19-30-6166</u>	
17. INFORMANT <u>metane n.c. R.F.D. - 3.</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) <u>50% Chaved Body.</u>		
(b) <u>Antecedent cause(s)</u>		
(c) <u>180</u>		

11. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/>	PLACE (Home, farm, factory, street, or other place) <u>Principals Furnace</u>	(CITY OR TOWN)	(COUNTY) <u>Sevier</u> (STATE) <u>Ind.</u>
TIME (Month) (Day) (Year) (Hour) <u>3 10 51 2:15</u>	INJURY OCCURRED <u>While at work</u>	HOW DID INJURY OCCUR? <u>Cottage caught fire from stove</u>	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE Dr. H. C. Dockson (Degree or title) DATE SIGNED Ind - 3-13-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-14-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Lones Memorial</u>	LOCATION (City, town, or county) <u>Ind. Rural</u>
DATE REC'D BY LOCAL REG. <u>March 14 1951</u>	REGISTRAR'S SIGNATURE <u>Dr. H. C. Dockson</u>	24. FUNERAL DIRECTOR <u>W. A. Patterson &amp; Son</u>	ADDRESS <u>730869 Perryville, Ind.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
MAR 16 1951  
BUREAU A. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition  
in 18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

02524

Reg. Dist. No. 92

MM No. G 1-1 APR 2 1951

1. PLACE OF DEATH - COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Md. COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) Elkton		CITY (If outside corporate limits, write RURAL and give nearest town) Elkton	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) JOSEPH (First) PETER (Middle) SWIFT (Last)	4. DATE OF DEATH 3 23 1951	5. SEX M. 6. COLOR OR RACE White 7. SINGLE, MARRIED, WIDOWED, DIVORCED, SEPARATED Married	
8. DATE OF BIRTH 7-16-1887	9. AGE last birthday 63 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	
10b. KIND OF BUSINESS OR INDUSTRY Building Homes	11. BIRTHPLACE (State or foreign country) Liverpool, England	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Vincent Swift		14. MOTHER'S MAIDEN NAME no information	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY No. 214-03-3622	
17. INFORMANT Mrs. Joseph Miller			

## 18. MEDICAL CERTIFICATION

### 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Terminal Pneumonia Bilateral Bronchio

Antecedent cause(s)

(b)

Anemia, type unknown (4/2/51 akc)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

### 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

### 19a. DATE OF OPERATION

### 19b. MAJOR FINDINGS OF OPERATION

### 20. AUTOPSY?

Yes ☐ No ☒

### 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

### PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Dr. R. E. Dodson M.D. Elkton Md.

3-23-51

### 23. BURIAL, CREMATION REMOVAL (Specify)

### DATE THEREOF

### NAME OF CEMETERY OR CREMATORY

### LOCATION (City, town, or county)

### (State)

### DATE REC'D BY LOCAL REG.

### REGISTRAR'S SIGNATURE

### 24. FUNERAL DIRECTOR

### ADDRESS

Mar 24

F. K. Traeger

H. W. Pippin

Elkton Md.

510246



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

02526

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Port Deposit		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Port Deposit	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) 278 N. Main	
3. NAME OF DECEASED (Type or Print) Kathrine E. Waibel		4. DATE OF DEATH March 2, 1951 19	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Aug. 5, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 57 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Duke		14. MOTHER'S MAIDEN NAME Ellen OConor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS G. Fred Waibel, Port Deposit, Md.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Primary Cancer Liver		7 wks
155X Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
46f (c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cholecyxitis Acute		7 wks
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-15, 1951, to 3-2, 1951, that I last saw the deceased alive on 3-1, 1951, and that death occurred at 4:15 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial	DATE 3-5-1951	NAME OF CEMETERY OR CREMATORY West Nottingham	LOCATION (City, town, or county) Coloma, Md. Rural	(State)
DATE REC'D BY LOCAL REG. March 5, 1951	REGISTRAR'S SIGNATURE Dorcas E. Dougherty	24. FUNERAL DIRECTOR W.A. Patterson & Son Perryville, Md.		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 7 1951  
U. S. AIR FORCE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change in MARYLAND STATE DEPARTMENT OF HEALTH  
18 shown on:

2411 N. Charles Street, Baltimore

02525

# Form No. G 132 APR 6 1951 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>District of Columbia</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Veterans Administration Hospital</b>		STREET ADDRESS (If rural, give location) <b>327 L. Street, S.E. Apt. #12</b>	
3. NAME OF DECEASED (Type or Print) <b>FRED</b> (First) <b>B.</b> (Middle) <b>WEAVER</b> (Last)		4. DATE OF DEATH (Month) <b>March</b> (Day) <b>15</b> (Year) <b>1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>June 2, 1919</b>
9. AGE last birthday <b>31 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Howard University</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Fred B. Weaver</b>		14. MOTHER'S MAIDEN NAME <b>Inez Archer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>261-14-4917</b>	
17. INFORMANT AND ADDRESS <b>Hospital Records, VAH, Perry Point, Md.</b>			

## 18. MEDICAL CERTIFICATION

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

#### Immediate cause

(a) **/Hepatitis, infectious, viral/ Hepatoma, liver cell type**

#### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Acute yellow atrophy**

(c) **Acites**

INTERVAL BETWEEN ONSET AND DEATH  
**(4/6/51 akc)**

### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Jan. 22, 1951**, to **March 15, 1951**, and that the deceased died on **March 15, 1951**, and that death occurred at **6:25 A.M.**, from the causes and on the date stated above.

SIGNATURE **E. P. Brannon** (Degree or title) ADDRESS **VAH, Perry Point, Md.** DATE SIGNED **3-16-51**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Remove</b>		DATE THEREOF <b>3-16-51</b>		NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		LOCATION (City, town, or county) (State) <b>St. Augustine, Fla.</b>	
DATE REC'D BY LOCAL REG. <b>March 14, 1951</b>		REGISTRAR'S SIGNATURE <b>E. Brannon</b>		24. FUNERAL DIRECTOR <b>Pennington &amp; Son</b>		ADDRESS <b>Havre de Grace, Md.</b>	





MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

02527

Reg. Dist. No. 92

1. PLACE OF DEATH - COUNTY <i>Harri</i>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <i>Md</i> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Ellettsville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Union Hospital</i>		STREET ADDRESS (If rural, give location) <i>318 W. Lorraine Ave.</i>	
3. NAME OF DECEASED (First) <i>JAMES</i> (Middle) <i>ALLEN</i> (Last) <i>WELLS</i>		4. DATE OF DEATH (Month) <i>3</i> (Day) <i>27</i> (Year) <i>1961</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <i>MARRIED</i>	8. DATE OF BIRTH <i>12-11-1912</i>
9. AGE last birthday <i>38</i> yrs.		10. If under 1 year Months <i>3</i> Days <i>8</i> Hours <i>27</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, except retired) <i>Foreman</i>		10b. Kind of BUSINESS OR INDUSTRY <i>Iron works</i>	
11. BIRTHPLACE (State or foreign country) <i>Wilmington, Del.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Wells</i>		14. MOTHER'S MAIDEN NAME <i>Adelle Allen</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>708-01-7817</i>	
17. INFORMANT <i>Margaret Wells</i>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

819.5 Immediate cause (a) *Shock*

Antecedent cause(s)

170c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) *Lacerated Kidney*

(c) *Internal Injuries*

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS  
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/>		PLACE (Home, farm, factory, street, or office bldg, etc.) <i>Route 213</i>		(CITY OR TOWN) <i>Side Chest</i> (COUNTY) <i>Calvert</i> (STATE) <i>Md</i>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>3 26 50 P.m.</i>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <i>Auto hit concrete island then run out.</i>	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

*Dr. H. Dodson*

*Dr. E. Rising*

*9 Sun Md*

*3/27-61*

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>March 29, 1961</i>	NAME OF CEMETERY OR CREMATORY <i>Danvers</i>	LOCATION (City, town, or county) <i>Baltimore</i> (State) <i>Md</i>
DATE RECEIVED BY LOCAL REG. <i>Mar 28</i>	REGISTRAR'S SIGNATURE <i>FK Tragan</i>	24. FUNERAL DIRECTOR <i>H. W. Pippin &amp; Son</i>	ADDRESS <i>Ellettsville, Md.</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

523506



RECEIVED  
MAR 30 1951  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

02528

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY <u> Cecil </u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u> Tenn. </u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u> Elkton </u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u> Shouns. </u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u> Union Hospital </u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u> LE ROY </u> (First) <u> WILKIN </u> (Last)		4. DATE OF DEATH <u> 3 12 1951 </u> (Month) (Day) (Year)	
5. SEX <u> M </u>	6. COLOR OR RACE <u> White </u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u> Single </u>	8. DATE OF BIRTH <u> 7-13-1928 </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> Laborer </u>		10b. KIND OF BUSINESS OR INDUSTRY <u> No special kind </u>	9. AGE last birthday <u> 22 1/2 </u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u> Shouns Tenn U.S.A. </u>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u> Clifford Wilkin </u>		14. MOTHER'S MAIDEN NAME <u> Alvance Hall </u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> No </u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u> Hosp. Records </u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)  Fractured Base of skull.

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

11. OTHER SIGNIFICANT CONDITIONS  
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING ☐ CAUSE OF DEATH

PLACE (Home, farm, factory, street, office, etc.) OF INJURY  Road

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY  3 12 00 1951

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

Car turned over hit Road.

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Mar 19

H. H. Piffin

H. H. Piffin & Son

Elkton Md.

970000

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

02529

Reg. Dist. No. 92

1. PLACE OF DEATH: COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Tenn. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Marion Sum Hill</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Shovins</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <i>WADE</i> (First) (Middle) (Last) <i>WILLEN</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>3 17 1951</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <i>Single</i>	8. DATE OF BIRTH <i>Jan 8 - 1935</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Driver</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Commercial</i>	9. AGE last birthday <i>16 1/2</i> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Tenn</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Clifford Willem</i>		14. MOTHER'S MAIDEN NAME <i>Lourence Hall</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY No.	
17. INFORMANT			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *Crushed face.*

Antecedent cause(s)

Disease or condition, if any, giving rise to the above cause stating the underlying cause last

170c

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING ☐ PLACE (Home, farm, factory, street, etc.) *Shovins Rd Cecil Md*

TIME (Month) (Day) (Year) (Hour) OF INJURY *3 17 51 11* INJURY OCCURRED *While at work*

HOW DID INJURY OCCUR?

*Car turned over hit concrete*

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

*J. L. Rodson MD*

(Degree or title)

ADDRESS

*Marion Sum Hill*

DATE SIGNED

*3-19-51*

23. BURIAL, CREMATION REMOVAL (Specify)

*Removal*

DATE THEREOF

*March 19, 1951*

NAME OF CEMETERY OR CREMATORY

*Hall Cemetery*

LOCATION (City, town, or county)

*Shovins, Tenn.*

(State)

REGISTRAR'S SIGNATURE

*H. L. Trager*

24. FUNERAL DIRECTOR

*H. W. Pippin*

ADDRESS

*Elkton Md.*

970000

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 20 1951  
BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

02530

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 92

1. PLACE OF DEATH - COUNTY <u>Cecil</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md.</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>295 Hollingwood Manor</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Roy</u> (Middle) <u>Clyde</u> (Last) <u>Wright</u>	4. DATE OF DEATH (Month) <u>3</u> (Day) <u>15</u> (Year) <u>1951</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12-20-1841</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE last birthday <u>3</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Elkton Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clyde M Wright</u>		14. MOTHER'S MAIDEN NAME <u>Mary Leox</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mary Wright</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) 50% Anterior Surface of body scalded.

## Antecedent cause(s)

(b) 917.0 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last181

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office, etc.) OF INJURY Home

CITY OR TOWN

COUNTY

STATE

TIME (Month) (Day) (Year) (Hour) OF INJURY 3 14 51 8:00 m.INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

Pulled pot of hot coffee on himself

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Mar 18H. H. FrazerH. W. Pippin above Elkton Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

